ADA Complementary Paratransit Service

Detroit Department of Transportation
1301 East Warren, Detroit, Michigan 48207
General Information: (313) 933-1300
Toll-Free: 1 (888) DDOT-BUS
Michigan Voice Relay: 1 (800) 649-3777
TTY: (313) 834-3434 (Hearing Impaired)
http://www.ci.detroit.mi.us/ddot

What is the ADA Complementary Paratransit Service?

It is a Paratransit Service provided by the Detroit Department of Transportation (DDOT) and the Detroit People Mover. Its primary purpose is to provide individuals determined as ADA Paratransit-Eligible with transportation when they are unable to use regular accessible fixed route buses to meet their travel needs. While this service is available through other transit systems nationwide, once determined eligible by DDOT, under certain conditions your eligibility may be used on other ADA Complementary Paratransit Transit Systems.

DDOT provides its Paratransit Service through the *Detroit MetroLift Transportation Company*. Vehicles provided for the Paratransit Service are designed to better meet the needs of the physically disabled passengers; as the buses are smaller than buses used on the regular fixed route service. The Paratransit Service is a unique service that caters to the passenger's travel needs. As an ADA Paratransit-Eligible Passenger, you are able to request a paratransit bus pick-up from your location and request a transport to a desired destination. Because of this uniqueness, this service falls outside the characteristic of DDOT's Regular Fixed Route Service. As a result, eligibility not only determines ***if*** you are eligible, but it also determines ***when*** and under ***what conditions*** you qualify for the service.

The attached application is designed to help DDOT determine your eligibility and any conditions. The information obtained specific to this application will be used only by the Department of Transportation, the Detroit People Mover and the Federal Transit Administration, or its agent, for the provision of public transit services. This information will be kept confidential and will not be provided to any other person or agency.

Please make sure the application is completed in its entirety before submitting. ***Failure to complete each section in its entirety could result in the applicant being denied eligibility.*** All incomplete applications will be returned for completion. Upon receiving a completed application, DDOT will record it as "Received"; at which time a 21-day processing period begins. This period is the amount of time DDOT has to review and determine your eligibility. If we are unable to determine your eligibility within the 21-day period, you will

automatically receive Temporary ADA Paratransit-Eligibility Status. This will allow you ***temporary eligibility*** until a final decision is made on your application.

Once DDOT makes a determination on your eligibility, you will be notified in writing, to the address on the application. If your application is certified as "Eligible", you will receive an eligibility approval letter along with instructions on completing the eligibility process. If your application for certification is denied, you will receive a denial letter along with instruction on accessing the Eligibility Appeal Process.

Please send your completed application to the following address for processing:

Detroit Department of Transportation
Special Fares Division
Attn: Paratransit Eligibility
1301 East Warren
Detroit, MI 48207

If there are any questions, please feel free to give us a call at (313) 933-1300 or respond in writing to the above address.

Sincerely,

The Detroit Department of Transportation

For Office Use Only
Marketing Received on: _____
Special Fares Received on: _____

DETROIT DEPARTMENT OF TRANSPORTATION
And THE DETROIT PEOPLE MOVER
Application to Determine ADA Paratransit Eligibility

Part I: GENERAL INFORMATION

(Print or Type)

Date of Application: _____/_____/_____

Social Security Number: _____ ****Required for identification purposes****
(Application will NOT be processed without social security number)

Date of Birth: _____/_____/_____
(Month/Day/Year)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt #: _____

City: _____ State:_____ Zip: _____

Telephone Numbers: (Daytime): (_____) _____ Extension: _____

(Evening): (_____) _____

(TDD): (_____) _____

In Case of Emergency Information:

Emergency Contact Name:
_____
(First Name) (MI) (Last Name)

Telephone Number: (_____) _____ Extension: _____

Alternate Format Request:

Do you need information provided in an alternate Format or Language? ❑ Yes ❑ No

If Format, please select one: ❑ Large Print ❑ Audio Tape ❑ Braille

If Language, please select one: ❑ Spanish ❑ Arabic

Part II: DISABILITY INFORMATION

Failure to complete each section in its entirety could result in the applicant being denied eligibility*

The applicant's eligibility is based primarily upon the information provided in the following 4-categories.

A. Visual Impairments

Please enter an "X" in each box that describes your impairment(s):

- ❑ Totally Blind
- ❑ Severely Blurred/Distorted Vision
- ❑ Light Perception
- ❑ Night Blindness
- ❑ Severe Glare Sensitivity
- ❑ Mildly Blurred/Distorted Vision
- ❑ Central Visual Field Loss
- ❑ Tunnel Vision
- ❑ Half-Field Losses
- ❑ Other

B. Mobility Impairments

Please answer each of the following questions:

1. Do you use a walker or cane when traveling outdoors?……. ❑ Yes ❑ No
2. Do you use a wheelchair (power or manual) or scooter when traveling?….. ❑ Yes ❑ No
3. Can you pull open a door and go through?……. ❑ Yes ❑ No
4. Can you raise a cup of water to your mouth without spilling any?……..… ❑ Yes ❑ No

C. Cognitive Impairments

Please answer each of the following questions:

1. Do you require help to communicate with people? …….. ❑ Yes ❑ No
2. How do you get information on how to ride the bus or train? _____

   _____

   _____
3. Do you get the information without any assistance from anyone? …….. ❑ Yes ❑ No

Cognitive Section continues…

4. Do you read and understand the information you receive without any assistance? ……..……. ❑ Yes ❑ No

5. How do you pay your fare when you ride the bus, trolley or People Mover? _____

   _____

6. If you were riding the bus or train and forgot where you were supposed to get off to transfer to the next bus or train, would you ask the driver to help you? ……..…… ❑ Yes ❑ No

7. Would you ask a passenger for help? ……..……. ❑ Yes ❑ No

8. Tell me how to get to your bus stop. _____

   _____

   _____

9. What is the name or number of the bus route you use most?

   Route #:_____ Route Name: _____

10. On the bus route that you take most often, from what locations do you get on and off the bus?

    On at:_____ Off at: _____

11. What other bus routes, trolley or People Mover trips might you take?

    _____

    _____

12. Do you understand the route information that is shown on the fronts and over the doors of Public Transit Vehicles (buses, trolleys, etc)? …….. ❑ Yes ❑ Yes, with assistance ❑ No

Cognitive Section continues…

13. Based on the displayed route information, can you tell which bus you should ride and identify the "Pick-Up" location for that bus route? ……..…. ❑ Yes ❑ No

14. Do you wear a watch? ……. ❑ Yes ❑ No

15. Do you ever look at your watch to see if the bus is on time? ……..…. ❑ Yes ❑ No

16. If you had to cross a busy roadway intersection, and the traffic lights were not working, what would you do? _____

_____

_____

17. Have you ever changed buses or gotten off the bus, People Mover or trolley in a busy downtown area? …….. ❑ Yes ❑ No

18. If yes, were you able to find your way back to your bus stop or rail station on your way back from the busy downtown area? ❑ Yes ❑ Yes, with assistance ❑ No

19. If you could not find your way, tell me what you did. _____

_____

_____

20. Have you ever gotten off at the wrong stop or People Mover Station? ❑ Yes ❑ No

21. If you have, tell me what you did when you realized that you were at the wrong place. _____

_____

_____

D. <u>Other Medical Conditions</u>

Please explain your medical condition in detail:

_____

_____

_____

_____

_____

Part III: PRESENT MEANS OF TRAVEL

1. Do you currently use Detroit Department of Transportation (DDOT) or the Detroit People Mover Services? …… ❑ Yes ❑ No

   a) If yes, what type of public transportation do you currently use? ***(Check all that apply)***

   - ❑ Accessible (Wheelchair Lift-Equipped) Large Bus Regular Fixed Routes
   - ❑ Detroit MetroLift Paratransit Service
   - ❑ Downtown Trolley
   - ❑ Detroit People Mover
   - ❑ Human Services Agency Transportation (Senior Center, MCB, etc.)

   b) If no, what kind of transportation do you currently use? ***(Check all that apply)***

   - ❑ Friend/relative drives me
   - ❑ Private taxi, car or van service
   - ❑ Drive myself
   - ❑ Walking
   - ❑ School bus
   - ❑ Other: _____

2. Do you receive a fare or voucher from a human service agency for your transportation? ……..…… Yes No

3. Which of the trips listed below describes your <u>most frequently</u> made trip? ***(Check only one)***

   - ❑ Home to work (& return)
   - ❑ Home to health care (& return)
   - ❑ Home to school (& return)
   - ❑ Dialysis appointments (& return)
   - ❑ Home to shopping (& return)
   - ❑ Home to recreation (& return)
   - ❑ Home to personal business
   - ❑ Other: _____

4. How long does it take to get to your <u>most frequently</u> made trip's location? _____

Present Means of Travel Section continues…

5. What assistance is required while traveling? (Check all that apply)

- ❑ Support Cane
- ❑ Long Cane (White)
- ❑ Scooter
- ❑ Wheelchair (Manual)
- ❑ Crutches
- ❑ Other
- ❑ Electronic Travel Aid
- ❑ Service Animal (Guide Dog)
- ❑ Wheelchair (Power)
- ❑ Walker
- ❑ Personal Care Attendant*

**** Person who helps you with daily needs (Not provided by Detroit MetroLift)***

Part IV: CERTIFICATIONS

A. Applicant's Signature:

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in the denial of service. I understand all information will be kept confidential, and only the information required to provider the services that I request will be disclosed to those who perform those services.

Applicant's Signature: _____ Date: _____

*****Applicant must be 18 years of age to sign independently; Otherwise, the signature of a guardian is required.***

Certification Section continues…

B. Applicant's Representative:

Person completing form if other than applicant ***(Please Check One):***

- ❑ I certify that the information provided in this application is true and correct, based upon information given me by the applicant.

- ❑ I certify that the information provided in this application is true and correct, based upon my own knowledge of the applicant's health condition or disability

Exceptions or Additions:_____

_____

_____

Print Name: _____
(First Name) (MI) (Last Name)

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Applicant: _____ Phone Number: (____)_____

Signature: _____ Date: _____

Note: This completes the applicant's portion of the Application to Determine ADA Paratransit Eligibility. The following section must be completed and signed by a Health Care Professional. Please refer to the following section, "Part V: Medical Verification, Professional Credentials", to determine those who qualify as Health Care Professionals.

Part V: MEDICAL VERIFICATION

The Americans with Disabilities Act of 1990 (ADA) requires that DDOT provide Paratransit Services (i.e. small bus, van/sedan) in the following situations: 1) The individual has a qualifying disability and is unable to use DDOT's regular fixed route lift-equipped buses; 2) and the individual is traveling within DDOT's Bus Service Area. The above applicant is requesting this service of DDOT based upon their current disability. Please understand that the ADA Paratransit Service is intended *ONLY* for those trips that the individual cannot make on DDOT's r*egular* Fixed Route Bus System.

The information requested below is intended to determine when, and under what circumstances, it is feasible for the applicant to use DDOT's Fix Route Service; as well as to determine when the individual will require paratransit services.

A. Professional Credentials:

THIS PAGE *MUST* BE COMPLETED BY ONE OF THE FOLLOWING CURRENTLY LICENSED, CERTIFIED OR REGISTED HEALTH CARE PROFESSIONALS: ***(Please check the one that applies):***

- ❑ Vocational Rehabilitation Counselor
- ❑ Special Education Teacher
- ❑ Social Worker
- ❑ Registered Nurse
- ❑ Psychologist
- ❑ Recreation Therapist employed by a medial facility
- ❑ Orientation & Mobility Instructor of the blind
- ❑ Travel Trainer
- ❑ Physician's Assistant
- ❑ Physician
- ❑ Physical Therapist
- ❑ Occupational Therapist
- ❑ Nurse Practitioner
- ❑ Mental Health Counselor
- ❑ Chiropractor

B. Professional Opinion:

Please carefully review the information provided by the applicant in Parts II & III of the above application. Please use the reviewed information to answer the following questions. Your answers should include more than just "Medical Diagnosis".

1. Please describe the applicant's physical and/or physical conditions:_____

   _____

   _____

2. Does this disability functionally prevent the applicant from using regular DDOT Lift-Equipped Bus Service: ***(Please note exceptions or additions below)*** ……. ❑ Yes ❑ No

   _____

   _____

3. Is this condition temporary? ……... ❑ Yes ❑ No

   a) If "Yes", for how many months? _____

Medical Verification's Section continues…

4. To the best of your knowledge, is the information provided in Parts II & III of this application true and correct***? (Please note exceptions or additions below)*** ❑ Yes ❑ No

_____

_____

C. Professional's Signature:

I certify that the statements contained in Part VI of this application are true and accurate.

Signature: _____ Date: _____

Print Name_____ Print Title: _____

State of Michigan License, Certification or Registration Number: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____

If necessary, please continue your description of the applicant's ability to function below:

_____

_____

_____

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